NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Sovaldi: Continuation PA Form

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ 4 more weeks ☐ 16 more weeks ☐ 40 more weeks

Clinical Information

1. Have HCV RNA labs been collected four (4) or more weeks after the initial prescription fill date? (Medical documentation with results are required)? ☐ **Yes** ☐ **No**
2. Do the results of the HCV RNA labs indicate a response to therapy (>/= 2 log reduction in HCV RNA or HCV RNA < 25IU/ml)? ☐ **Yes** ☐ **No**

   At week 4 of the treatment cycle:
   HCV RNA (IU/ml): _____
   And/or log 10 value: _____

   Before treatment documented on original Prior Authorization request:
   HCV RNA (IU/ml): _____
   And/or log 10 value: _____

3. Has the beneficiary exhibited any sign of high risk behavior (ex. recurring alcoholism, IV drug use, etc.)?
   ☐ **Yes** ☐ **No**
4. Has the beneficiary failed to complete HCV disease evaluation appointments or procedures?
   ☐ **Yes** ☐ **No**
5. During the initial course of therapy, was the beneficiary compliant with the prescribed medication regimen?
   ☐ **Yes** ☐ **No**
6. Has the beneficiary's medication fill history been reviewed for compliance? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.